# RALF FREQUENTLY ASKED QUESTIONS

# **Contents**

# (Click on title to go to each section)

Admissions, Retention, Discharge	1
Billing, Charges, Admission Agreements, Required Services	<i>6</i>
Dining, Food Safety, Special Diets	
Incidents, Accidents, Abuse, Reportable Incidents	13
Medications, Orders, Medical Procedures	
Outside Services	26
Resident Rights, Behavior Management, Privacy, Confidentiality	27
Safety, Environment, Restraints	
Staffing, Staff Roles, Employee and Contractor Records	37
Survey and Licensing	40
Miscellaneous	

Question	Answer
Admissions, Retention, Disch	narge
Does everyone who lives in AL have to have a nurse assessment even if they do not need any services at present?	Yes. Each resident of the assisted living falls under all rules at IDAPA 16.03.22 (3/18/09).
Does the nursing assessment need to be done before the resident moves in?	If the resident takes medications, or receives any medical treatments (dressing changes, oxygen, etc.) then yes, the nurse needs to do the assessment before, or on the day of move in. The nurse must review the resident's current medication

	orders and/or need for treatment, and then either delegate to staff the assistance with those medications/treatments, or perform a self-administration assessment. A face to face assessment is required for each of these. If the resident does not take medications, and receives no medical treatment, the nursing assessment should be done within the first 14 days, so the nurse's recommendations can be included on the NSA. The administrator is responsible to assure before the resident moves in, that the facility can meet the resident's needs (1/14/08).
Are residents with NG tubes	There is no rule prohibiting residents with an NG tube. However, feeding and
(nasogastric), allowed to	medication administration through the tube cannot be delegated per the BON rules
reside in our facility?	23.01.01.490.06.b.v. Thus, the facility would need a licensed nurse present at all
	times to conduct feeding and medication administration (11/09/10).
Is a Morphine Pump that the	Yes, as long as the information on what to watch for has been obtained from the
Dr. checks and fills weekly	Dr.'s office and the nurse has delegated to the staff to watch for those
acceptable?	complications. The pump and the staff's responsibilities should be described in the
	NSA. The morphine pump referred to, is subcutaneous not through an IV
M/a la accada a a la discon	(3/19/08).
We have been told a sliding scale for insulin is	For the injection, we would expect the resident be fully cognizant of what the
appropriate in the RALF	injection is for and how it is to be given. The only time hand over hand would be appropriate, is when the resident is cognitively capable, but has difficulty
setting even if they are	manipulating or holding steady the syringe. Further, per the Board of nursing,
unable to manage it entirely	dialing insulin pens is not a task that should be delegated to UAP. For any
on their own including the	medications, UAP are able to give a set dose at a set time. They are not able to
injection. What is your	make judgments or distinctions, such as "1-2 tablets" or "every 2-4 hours." The
position on this?	same would hold true for the insulin dose based on the Blood glucose level
	(6/11/07).
Are PICC lines allowed in	PICC lines require sterile dressing changes. The nurse must do the dressing
RALFs?	changes. Additionally, the nurse must be on-sight to monitor for complications and
	stay start to finish for the IV treatment (the nurse cannot start the IV and let UAP
	disconnect). In addition, the nurse needs to provide training for staff on what to do
	in an emergency and what to watch for with regard to the PICC line when IV
	treatment is not in progress and the nurse is not present. Continuous IV therapy is
	prohibited in RALFs. (IDAPA 16.03.22.152.05.b.ii) (7/15/09).
Are Jackson-Pratt drains	JP drains would be fine in a RALF if it was for a short-term treatment and the
allowed in RALFs?	resident was alert and oriented. The LN must delegate the task with clear and

specific directions. Staff must know when to call the nurse, and the nurse must be very involved while the JP drain was in use (10/10/07).
Only if the resident could care for the tracheotomy themselves (8/06/07). IDAPA
16.03.22152.5.b.vi. states that a resident who has a tracheotomy who is unable to
care for it themselves will not be accepted as a resident (03/30/06).
The Nurse needs to come in and assess the resident and provide resident and
facility staff education on how to properly care for the colostomy. The nurse also
needs to meet with staff face to face to delegate to staff individually how to care for
the colostomy. Ensure the UAI and NSA are updated to reflect these changes. The
nurse should come back in to follow-up and ensure care of the colostomy is
appropriate (4/13/07).
As long as the facility nurse is versed in colostomy care and trains staff before they
assist. It should be addressed in the NSA and nursing assessments. Staff training
and delegation should be documented (11/12/08).
No. Continuous IV therapy is prohibited in RALFs: See IDAPA 16.03.33.152.05.b.
(12/19/07).
(12/17/07).
Yes. The nurse needs to monitor every 90 days the resident's continued ability to
manage this, as well as the resident's response to the dialysis. IDAPA
16.03.22.305.01 states the licensed professional nurse must assess and document
the resident's Response to Medications and Therapies, as well as, conduct a nursing
assessment of each resident's response to medications and prescribed therapies
(4/2/07).
If the facility is unable to care for the resident or if the resident requires skilled care
or care not within the legally licensed authority of the facility, then the resident
should be immediately discharged to an appropriate level of care. If the resident is
waiting to get into a particular facility, then they should be transferred to a different
facility at an appropriate level of care, rather than stay at the assisted living facility
until the preferred facility has an opening. IDAPA 16.03.22.05.a. states a resident
will be admitted or retained only when the facility has the capability, capacity, and
services to provide appropriate care, or the resident does not require a type of
service for which the facility is not licensed to provide or which the facility does not
provide or arrange for, or if the facility does not have the personnel, appropriate in
numbers and with appropriate knowledge and skills to provide such services; b. No

	resident will be admitted or retained who requires ongoing skilled nursing or care not within the legally licensed authority of the facility (4/13/07).
If the ulcer then heals before	No, provided there is documentation the ulcer is healed and a plan is in place to
the notice, do they still have	prevent further skin breakdown (9/17/08).
to move?	
Does a resident who had a	No. A positive skin test does not mean the resident is contagious. Further testing is
positive skin test for	necessary. The physician can determine if the resident is currently contagious. If
Tuberculosis need to be	so, the facility must immediately report to the local health authority and follow their
immediately discharged?	direction. See IDAPA 16.03.22.335.04 (10/13/10).
Is it OK to keep a resident	No. The definition of an unstageable pressure ulcer according to the National
with a pressure ulcer that is	Pressure Ulcer Advisory Panel: Full thickness tissue loss in which the base of the
not able to be staged?	ulcer is covered by slough and/or eschar. So, by definition, an unstageable
	pressure ulcer is beyond a stage II (10/13/10).
If a resident develops a stage	No. As long as the facility has the capability to meet the resident's needs, they can
III pressure ulcer, does the facility have to discharge the	give a 30 day discharge notice. The NSA must include the plan regarding the
resident immediately?	resident's skin care needs. There must be enough appropriately trained staff available to meet the resident's mobility/turning needs. If the facility is unable to
resident infinediately:	implement measures to prevent further breakdown, the resident should be
	immediately discharged to a facility that has that capability. If the resident's
	pressure ulcer is no longer greater than a stage II by the end of the 30 days, the
	facility may rescind the discharge notice (10/13/10).
A home health agency says	No. See IDAPA 16.03.22.152.05.ix. Also, the facility nurse needs to monitor the
they treat stage III pressure	skin condition (physically assess it) to assure the outside agency is providing
ulcers in other RALFs "all the	appropriate care and to make certain resident is still appropriate per the RALF rules
time." Is it okay to retain	(10/13/10).
someone with a stage III	
pressure ulcer as long as the	
wound in being treated by	
home health or hospice?	
We have a resident who	No. A facility should only take residents for whom they are capable of caring for all
wants to move in with a	of their medical needs. Families are not always consistently available and
suprapubic catheter, but we	circumstances can change. This is why facilities are not allowed to let family
are unable to take care of the	manage any of the cares the facility is responsible for (10/15/08).
catheter. Is it ok for the son	

to come in and take care of	
the catheter?	
If a resident has a stage III	No. The intent of the rule is to ensure RALFs do not admit or retain residents who
or IV pressure ulcer debrided,	require skilled nursing care. This resident would still be at high risk and should be
is it okay for the facility to	in skilled care until the wounds heal (10/15/08).
admit or retain the resident	, ,
since it is now a surgical	
wound?	
One of our residents was	No. IDAPA 16.03.22.152.05.e. states the facility cannot admit or retain any
found with a plastic bag over	resident who is a danger to himself or others. A resident who attempts suicide is
her head. She had tried to kill	considered a threat to themselves, and therefore should not be admitted or retained
herself. The hospital wants to	in an AL (10/29/08).
send her back here. Can re-	
admit?	
The husband of one of our	No. IDAPA 16.03/22/012/14 states any adult, other than the owner, administrator,
residents wants to move in,	their immediate families, or employees who lives in a residential care or assisted
but does not need any help.	living facility is considered a resident (10/29/08).
Can he live here without	
being a resident?	
A resident has a new G-tube	You will have to wait 21 days to admit. Bolus feedings are allowed as long as the
and will require bolus	nurse is well versed and provides staff training before staff assist with feedings. It
feedings. Is this appropriate	should be addressed in the NSA and reviewed by the nurse quarterly or more often
for AL?	as needed. Staff training and delegation must be completed and documented
	(11/12/08).
A resident's MD emailed me	Yes. The MD orders do not have to be followed if they resident/responsible party
that we should move her to a	are aware of the risks of not doing so and as long as the facility is following AL rules
SNF. The resident is mobile,	(11/12/08).
independent and does not	
have any conditions to	
indicate she is above level of	
care. There does not appear	
to be a medical reason she	
should move to a SNF. Can	
the resident and her POA sign	

a statement indicating they	
are aware of the MD's order	
but choose to have her	
remain in AL?	
Is a person who needs a two-	They can be, but the facility would have to have at least 2 staff on around the clock
person assist with transfers	to provide the assistance (12/8/08).
appropriate for admission to	
a RALF?	
Is a resident with a Porta	There is no rule prohibiting these in AL. The nurse should be assessing, monitoring
Catheter appropriate for	and documenting on quarterly assessments. Staff should know what it is so they
admission?	can report any changes to the nurse, but should not be involved in the use or care
	of the Porta Cath (2/4/09).
A resident is perpetually late	In this case, it would be appropriate to discharge the resident, as the resident is
on rent and has not paid his	placing himself in danger if he is refusing to purchase medications. A referral
pharmacy bill. His girlfriend is	should be made to Adult Protection if the girlfriend is misusing the resident's funds
the payee. Is it okay to	(3/4/09).
discharge the resident if he	
runs out of critical	
medications because the	
pharmacy bill is not being	
paid, or is the facility required	
to purchase them for the	
resident?	
May a mentally ill resident	If the person is their own guardian and state they do not want to live in a secure
live in a secure environment?	environment, having them do so could be a violation of their rights. A secure
	facility should not house residents who do not require a secure environment or who
	have not consented (3/18/09).
Billing, Charges, Admission A	Agreements, Required Services
IDAPA 16.03.22.430.05	Yes, medication assistance has to be included in the base monthly rate. However,
reads: Basic services. The	the formulas used to determine the resident's base monthly rate could include a
1	

following are basic services to be provided to the resident by

the facility within the basic

\$400 charge if they needed assistance with medication. Prior to move in, the facility

must disclose to the resident what their base monthly rate will be, how the rate was

calculated, and all the services it includes. The facility must also disclose to the

service rate: a) rent, b)
utilities, c) food, d) activities
of daily living, e) supervision,
f) first aid, g) assistance and
monitoring of medications, h)
laundering of linens owned by
the facility, i) emergency
interventions and
coordination of outside
services, j) routine
housekeeping and
maintenance of common
areas and k) access to basic
television in common areas.

resident their pricing methodologies and formulas, so the resident will be able to determine how much more it will cost if they need additional assistance. The base monthly rate does not change from month to month. It only increases when the resident and facility enter a new negotiated service agreement, or upon a thirty day notice that the facility is increasing it's prices (11/10/10).

Do we have to include charges for medication assistance in the base monthly rate, or is it okay to charge the base monthly rate, plus an additional \$400 if they need assistance with meds?

How is cafeteria pricing allowed when the basic service rate must include assistance with activities of daily living? While the facility can use service plans, points systems and other charging methodologies, the systems used must produce a static, basic rate that the resident can expect to pay each month. This rate must include all items described under the basic services rate, and may only be increased upon a re-negotiation of the negotiated service agreement or a 30 written notice. Items not required to be included in the basic services rate, such as transportation to community activities, can be charged on a fee for service basis. The resident's charges for these items could fluctuate each month, depending on usage, as long as the charges had been clearly described in the admission agreement and are itemized on the monthly bill: see IDAPA 16.03.22.220.02 & .03 (11/10/10).

If the increase is not agreed

No. If the resident/resident representative decides to move out, the facility can only

to by the resident/resident	charge for the days the resident continues to live in the facility and receive the
representative and the facility	services; see IDAPA 16.03.22.010.29, 220.02 & 550.23 (11/10/10).
starts charging the rate after	Scrvices, See IDALA 10.03.22.010.27, 220.02 & 330.23 (11/10/10).
the 5 days, is the resident	
required to give a 30 day	
notice and pay for the	
increased needs for 25 days?	
If our facility does not intend	No, not if the current admission agreement meets all of the rules regarding
to change our current billing	admission agreements. Review your current agreement, to ensure the facility
practice, do we need	admission agreement meets all of the requirements under IDAPA 16.03.22.220 and
to update our current	221, paying particular attention to the following new sections: IDAPA
admission agreement?	16.03.22.220.02, 220.03, 220.10, 220.13, 220.16, and 220.17 (11/10/10).
If a resident has a change in	Yes, as long as the admission agreement clearly explains this is what will happen;
condition can the facility	the nurse must have assessed, documented, and provided training for the resident's
begin charging the increased	change of condition; the NSA must have been updated to reflect the new cares; the
rate after a 5 day period even	services must be evident, observable and documented as being provided to the
if the resident has not agreed	resident. Refer to IDAPA 16.03.22.300.01, 305.01-08, 320.05, 320.08 & 550.23
to the new rate?	(11/10/10).
Can we put in our admission	Yes. IDAPA 16.03.22.220.17. Transition to Publicly-Funded Program. The facility
agreement that if someone is	must disclose the conditions under which the resident can remain in the facility, if
funded by Medicaid, then they	and when payment for the resident shifts to a publicly-funded program (11/10/10).
will be in a semi-private	
room, and, if they start as	
private pay, then transition to	
Medicaid that they will have	
to move to a semi-private	
room?	
Do we need to list in the	Yes. IDAPA 16.03.22.220.02. Written Agreement (private pay). Prior to or on the
admission agreement all	day of admission, the facility and each resident or the resident's legal guardian or
services and supplies that	conservator must enter into a written admission agreement that is transparent,
could be charged to a	understandable, and is translated into a language the resident or his representative
resident (for example; light	understands. The admission agreement must provide a complete reflection of
bulbs, batteries, briefs, chuck	the facility's charges, commitments agreed to by each party, and the actual
pads etc.) as well as each	practices that will occur in the facility. The agreement must be signed by all

items cost?	involved portice. A complete converget be precided to the resident and the
items cost?	involved parties. A complete copy must be provided to the resident and the resident's legal guardian or conservator prior to or on the day of admission. The
	admission agreement may be integrated within the Negotiated Service Agreement,
	provided that all requirements for the Negotiated Service Agreement in Section 320
	of these rules and the admission agreement are met. Admission agreements must
	include all items described under Subsections 220.03 through 220.18 of this rule
	(11/10/10).
Can we charge the resident	No. According to IDAPA 16.03.22.430.06 the facility must provide, at no cost to the
for non-sterile exam gloves	resident, liquid hand soap and non-sterile gloves. Gloves and liquid soap, along with
when the gloves are used to	paper towels, are essential to an effective infection control program (11/10/10).
provide incontinence care for	
the resident?	
Is it true that we can no	Yes. See IDAPA 16.03.22.430.06 regarding basic supplies. The following are to be
longer bill Medicaid for exam	supplied by the facility at no additional cost to the resident: linens, towels,
gloves?	washcloths, liquid hand soap, non-sterile exam gloves, toilet paper, and first aid
	supplies, unless the resident chooses to provide his own (10/13/10).
220.03.a Unless otherwise	No. The facility must meet the needs of the residents and must assure that policies
negotiated with the resident,	and procedures are in place to protect the resident from inadequate care and
resident's legal guardian or	neglect. IDAPA 16.03.22.520 & 525.
conservator, basic services	
must, at a minimum, include:	IDAPA 16.03.22.011.08 – Inadequate care. When a facility fails to provide the
iii Food and iv Activities of	services required to meet the terms of the Negotiated Service Agreement, or
Daily living. Does this mean	provide for room, board, activities of daily living, supervision, first aid, assistance
the facility is not required to	and monitoring of medications, emergency intervention, coordination of outside
provide these, even if the	services, a safe living environment, or engages in violations of residents rights or
resident needs them, as long	takes residents who have been admitted in violation of the provisions of Section 39-
as the legal guardian says not	3307, Idaho Code.
to?	
For example, the resident's	IDAPA 16.03.22.011.24 – Neglect. Failure to provide food, clothing, shelter or
legal guardian does not want	medical care necessary to sustain the life and health of a resident.
the resident to be assisted	
with transfers in the	IDAPA 16.03.22.940.02. Reasons for Revocation or Denial of a Facility License. (b)
bathroom, even though the	evidence that such conditions exist which endanger the health or safety of any
facility has assessed they are	resident; and 940.02.c Any act adversely affecting the welfare of residents is being

	,
not safe to transfer	permitted Such acts may include, but are not limited to, neglect, physical abuse,
themselves independently.	mental abuse, violation of civil rights, criminal activity, or exploitation (11/10/10).
Are there any protections or	Yes. 220.16. Contested Charges (private pay). The facility must provide the
means by which the resident	methods by which a resident may contest charges or rate increases that include
can dispute the increased	contacting the Ombudsman for the Elderly. The facility must respond as provided
rate?	under Section 711.02 of these rules which states the facility must assure that the
	individual resident's record documents complaints and grievances, the date it was
	received, the investigation, outcome, and the response to the individual who made
	the complaint or grievance (11/10/10).
What items and services can	1) The facility cannot charge additional fees to private pay or Medicaid
the facility charge or not	residents for the following items or services:
charge a resident for?	a) 430.01 - Common Shared Furnishings. Appropriately designed and constructed
	furnishings to meet the needs of each resident, including reading lamps, tables,
	and comfortable chairs or sofa. All items must be in good repair, clean, safe, and
	provided at no additional costs.
	b) 430.04 - Resident Telephone Privacy. The facility must have at least one (1)
	telephone that is accessible to all residents, and provide local calls at no
	additional cost. The telephone must be placed in such a manner as to provide the
	resident privacy while using the telephone.
	c) 430.06 – Basic Supplies. The following are to be supplied by the facility at no
	additional cost to the resident: linens, towels, wash cloths, liquid hand soap, non-
	sterile exam gloves, toilet paper, and first aid supplies, unless the resident
	chooses to provide his own.
	2) The facility can charge additional fees to private pay and Medicaid residents
	for the following items, if the facility provides them to the resident, but not if the
	resident chooses to supply their own or purchase them elsewhere:
	a) 430.07 - Personal Supplies. Soap, shampoo, hair brush, comb, electric razor or
	other means of shaving, toothbrush, toothpaste, sanitary napkins, and
	incontinent supplies must be provided by the facility unless the resident chooses
	to provide his or her own. The facility may charge the resident for personal
	supplies the facility provides and must itemize each item being charged to the
	resident.
1	

	3) The facility can charge private pay residents for the following items or
	services, but the charges must be included in the monthly rate, not as an add-on
	charge. (These cannot be charged to Medicaid residents):
	a) 220.03.f - (located under the admission agreements). The facility may charge
	residents for the use of personal furnishings, equipment, and supplies provided by
	the facility for private-pay residents. The facility must provide a detailed
	itemization of furnishings, equipment, supplies, and the rate for those items the resident will be charged.
	b) 430.05.a-k - Basic Services. The following are basic services to be provide to
	the resident by the facility within the basic rate: rent, utilities, food, activities of
	daily living services, supervision, first aid, assistance and monitoring of
	medications, laundering of linens owned by the facility, emergency interventions
	and coordination of outside services, routine housekeeping and maintenance of
	common areas and access to basic television in common areas.
	Medicaid residents cannot be charged for basic services (11/30/10).
Can the facility bill the	Yes, or the resident/family can bring them in. The facility is not required to provide
resident for incontinent	attends (3/19/08).
briefs?	
A facility includes cable in the	No. The admission agreement is signed and dated by each party and includes what
resident packet, but the price	services the facility has agreed to provide. The admission agreement can only be
of cable has gone up, can the	changed upon agreement by both parties, or, it can be terminated with a 30 day
facility implement a charge	written notice. The facility could capture the increased costs through a rate
for the cable, even though the	increase, but not by changing agreements made in the admission agreement. The
admission agreement states it	same situation applies if a resident agrees upon admission to pay a one-time pet
is included?	fee, and later, the facility wants to implement a monthly pet fee. See IDAPA
If a recident is unable to nov	16.03.22.220, 220.01 & 221.01 (11/30/10).
If a resident is unable to pay	No. The facility may not be able to retain the resident if the resident is endangering
for medications, does the facility have to pay for the	his/her health by not taking the medications. The facility should document all efforts to assist the resident to obtain his/her medication, explain to the resident
medications?	the risks associated with not taking the medications and document that you have
inedications:	explained the risk. The facility nurse should consult with the resident's physician to
	evaluate the level of risk, determine the most appropriate course of action and then
	document the results of the consult in the resident's record. See IDAPA

	16.03.22.711.04 (08/01/2012).	
Dining, Food Safety, Special D	Dining, Food Safety, Special Diets	
Do all staff need to show proof they have completed the Idaho Food Code course?	Our rules do not require this. However, employees who are responsible for meal preparation must demonstrate they have knowledge of the Idaho Food Code. This is necessary to protect residents from consuming potentially hazardous food. Therefore, while it is not a requirement to have certification, it is a best practice. The free online course is available at: <a href="http://healthandwelfare.idaho.gov/Health/FoodProtection/tabid/96/Default.aspx">http://healthandwelfare.idaho.gov/Health/FoodProtection/tabid/96/Default.aspx (11/09/10).</a>	
How long can we keep leftover food in the refrigerator?	The Idaho Food Code allows leftovers to be kept up to 7 days at a temperature of 41 degrees F or less. Day 1 is the day of preparation for the food. The Food Code regulates food safety and not food quality. Food quality will deteriorate the longer a food is kept. The 7 days also assumes the food was properly cooled and the temperature in the cooler doesn't exceed 41 degrees F. This means that you should be monitoring the temperature of the cooler on a consistent basis (10/13/10).	
Are pets allowed in food preparation areas?	No. Pets are not allowed in the food preparation area. They are also not allowed in common dining areas when meals are being served. See the Idaho Food Code 6-501.115 (11/09/10).	
Can a farmer donate lamb to a facility?	No. IDAPA16.03.22.004.03 states he cannot because meats must be USDA approved before use in assisted living facilities according to Idaho Food Safety and Sanitation Standards. Home canned fruits and veggies are not allowed because they are not pasteurized and may pose a risk for food poisoning (8/06/07).	
Can we serve game meat if we raise it?	No. All game animals have to be raised, slaughtered and processed under a voluntary inspection program. See Idaho Food Code IDAPA 16.02.19.320 & 325 (10/13/10).	
Can staff use the facility's kitchen to prepare their own food?	Yes. In a RALF this is allowed. However, any food, supplies and utensils, etc. for their own use must adhere to all Idaho Food Code requirements (5/18/09).	
We have a resident who was put on the "Heart Healthy Diet" can our kitchen staff just make substitutions out of the diet manual to	No. 451.03 requires a therapeutic diet menu planned or approved, signed and dated by an RD (5/18/09).	

accommodate this new diet?	
Incidents, Accidents, Abuse, Reportable Incidents	
If one resident is seen fondling another resident, even if we are not sure it was abusive, does it have to be reported to adult protection?	Yes. Adult Protection (AP) staff is trained to investigate allegations of abuse, neglect, self-neglect, and exploitation involving vulnerable adults and take remedial actions to protect them. Administrators who have failed to report potential abuse have been charged with a crime, lost their license and/or been banned from working in healthcare. You should always report potential and alleged abuse to AP even if you have personal doubts about the validity of the allegation. In addition to reporting to adult protection, the facility administrator is responsible to conduct an investigation, protect residents from further abuse during the investigation (usually suspending if the alleged perpetrator is staff or providing added supervision if it is a resident), prepare a written report of the finding, and take corrective actions for substantiated allegations. See sections 215.08 & 350.02 & 350.03 of IDAPA 16.03.22. and Idaho Code 39-5303; DUTY TO REPORT CASES OF ABUSE, NEGLECT OR Exploitation OF VULNERABLE ADULTS (10/13/10).
Is staff smoking pot on duty a reportable incident? Is staff stealing medications?	These do not meet the definition of a reportable incident. However, it should be immediately report to the administrator, who is responsible to conduct an investigation to ensure resident safety during the course of the investigation. Any illegal activity should be reported to the police (4/1/09).
Is elopement a reportable incident?	Yes, if it meets the definition of elopement in the rules. IDAPA 16.03.22.011.10.c. defines resident elopement of any duration as; when a resident who is unable to make sound decisions physically leaves the facility premises without the facility's knowledge (4/02/07).
Is each time a resident goes to the hospital a reportable incident?	Hospitalizations are reportable only if the hospitalization is a result of an incident. IDAPA 16.03.22.011.10.e. states an incident that results in the resident's need for hospitalization, treatment in a hospital emergency room, fractured bones, IV treatment, dialysis, or death. Incident. An event that can cause a resident injury (4/02/07).
A resident had an incident/fall off-site. Should this be reported to us?	Yes. The rule does not say anything about on/off site. The facility should still review and track (4/15/09).
If the facility discovers two residents have had sexual	Yes, it should be reported to the police department and to adult protection. Abuse is defined as the non-accidental act of sexual, physical, mental mistreatment, or

contact, but are unsure of the	
victim, should abuse be	
reported?	

injury of a resident through the action or inaction of another individual. TITLE 39 HEALTH AND SAFETY CHAPTER 53 ADULT ABUSE, NEGLECT AND EXPLOITATION ACT 39-5303. DUTY TO REPORT CASES OF ABUSE, NEGLECT OR EXPLOITATION OF VULNERABLE ADULTS. (1) Any physician, nurse, employee of a public or private health facility, or a state licensed or certified residential facility serving vulnerable adults, medical examiner, dentist, ombudsman for the elderly, osteopath, optometrist, chiropractor, podiatrist, social worker, police officer, pharmacist, physical therapist, or home care worker who has reasonable cause to believe that a vulnerable adult is being or has been abused, neglected or exploited shall immediately report such information to the commission. Provided however, that nursing facilities defined in section 39-1301(b), Idaho Code, and employees of such facilities shall make reports required under this chapter to the department. When there is reasonable cause to believe that abuse or sexual assault has resulted in death or serious physical injury jeopardizing the life, health or safety of a vulnerable adult, any person required to report under this section shall also report such information within four (4) hours to the appropriate law enforcement agency. IDAPA 16.03.22.215.08 states procedures for investigations states the administrator must assure the facility procedures for investigation of incidents, accidents, and allegations of abuse, neglect, or exploitation are implemented to assure resident safety (7/03/07).

# **Medications, Orders, Medical Procedures**

When does the nurse need to be contacted before giving or withholding medications?

If withholding medications, the nurse should be contacted at all times. For a medication that says hold if BP is less than (#), if the nurse has delegated blood pressures to staff, then staff can follow a direct order, i.e. "withhold medication" and then inform the nurse the medication has been withheld. However, PRN orders that are not black and white i.e. "1-2 tablets" "every 3-4 hours" would require decision making on the part of the staff. Therefore, the nurse would have to be called. If the resident is cognitive enough to request a med when needed, then staff could give the medication without calling the nurse (i.e. "give 2 Tylenol every 3-6 hours as needed for pain) (9/25/06).

# Can a UAP (unlicensed assistive personnel) give Liquid morphine to an

No. The Medication Assistance Course is taught with the assumption that the resident would otherwise be able to take their own medications except for unusual circumstances such as a physical disability, mental illness, etc. However, a resident

unconscious hospice	who is unconscious would not be able to take their own medications and therefore it
resident?	is no longer assisting it becomes administering. So the answer is no, a UAP may
resident.	not assist an unconscious resident with SL or other medications. Either the facility
	nurse or the hospice staff should handle this task (4/2/07).
Con a LIAD (unlicenced	
Can a UAP (unlicensed	No, straight catheter is considered a sterile procedure and cannot be delegated. See
assistive personnel) be	Board of Nursing (BON) rules IDAPA 23.01.01.490.b.i (10/13/10).
delegated to catheterize a	
resident?	
Can a UAP set O2 to the level	The UAP cannot perform an assessment to determine the level at which to set it O2,
specified in the physician's	or determine when O2 should be used or not used, or determine how long O2
order as long as the nurse	should be used for. If the order for O2 includes a range in the level or, decision
has delegated this task?	making about when to use the oxygen, such as "2-3 liters per minute" "PRN" or
	"when short of breath," the UAP cannot set the level. If the physicians order allows
	for no variation, i.e. "O2 - 2 liters per minute, continuous," and the med aid has
	received clear direction and delegation from the facility RN, then the UAP could
	assist the resident with applying the tubing and setting the level (2/22/07).
Irrigating Catheters: Are UAP	Only if the physician's order indicates a clean rather than a sterile procedure and
allowed to irrigate either	the order states it is acceptable for unlicensed personnel to perform and the facility
Foley or supra-pubic	nurse is comfortable delegating to staff. The physician's order must also specify
catheters?	what is to be used for the flush (4/16/08).
Can UAP assist with G-tube	Yes, as long as they have completed the expanded med assist course and the RN
meds?	has provided training and delegation (10/12/06).
Are Caregivers allowed to	No. Only an RN or LPN may take telephone orders from a physician. The RN does
take telephone orders from a	not need to delegate this task to a LPN for it is within the LPNs scope of practice.
physician?	However, the facility must ensure a copy of the actual written, signed, and dated
priysicians	
	orders, by a physician are obtained and placed in the record within 72
	hours (7/19/06). Additionally, the order can be taken by the facility nurse, or the
	resident's hospice or home health nurse.
	IDAPA 16.03.22.711.09 09. Current List of Medications, Diet and Treatments. A
	current list of medications, diet, treatments prescribed for the resident which is
	signed and dated by a physician or authorized provider giving the order (4/2/08).
Can the LPN delegate UAP to	Yes, the LPN can determine if the PRN should be given as long as the RN approves
assist with PRNs?	this practice (2/8/08).

Do you have to document the results of PRNs?	It is best practice to document the results of PRNs, on the back of the MAR, or elsewhere, although our rules do not specify results must be documented or where they must be documented. However, in order for the facility to comply with 16.03.22.305.01 and 16.03.22.305.7, documenting the results of PRNs enables the facility RN to evaluate the effectiveness of prescribed medications (2/8/08).
Can a physician delegate	Yes (3/19/07).
directly to the facility LPN?	V (0/40/07)
Can a physician rather than	Yes (3/19/07).
an RN sign the care plan?	
Does the nurse have to	No. These tasks do not need to be delegated. However, UAP cannot cut the
delegate baths, hair combing,	toenails of a person with diabetes (5/21/07).
toenails, etc.?	
When a resident falls we were	Unlicensed Caregivers can be trained to take vitals and direct the resident in ROM
recently told that the nurse	tasks. The nurse would need to provide face to face training for staff and document
first had to assess them	the delegation. When called, the nurse could determine, based on the resident and
before they were helped up	the information reported by staff, if 911 needed to be called. If 911 was not called,
from the floor. Is it possible	the nurse should come in and do an assessment to ensure the resident is ok
for it to be a phone	(6/11/07).
assessment by the nurse or	
do they need to come in? Our	
nurse has instructed the staff	
to ask the resident to do	
various ROM tasks to	
determine if an unobvious	
fracture is present. She	
would be happy to do this	
over the phone but was	
unaware that she needed to	
come in for every fall. Please	
advise.	
Can the RN delegate	An LPN can work under the direction of an RN within the LPN's scope of practice.
assessments to the LPN?	The LPN can gather the data, but the RN is responsible for the assessment. The RN
	must visit the facility every 90 days and when there is a change in the resident's
	condition. The RN must also assess and document, including date and signature,

	for each resident as described in IDAPA 16.03.22.05.305.
	16.03.22.305.LICENSED PROFESSIONAL NURSE
	RESPONSIBILITIES
	The licensed professional nurse must assess and document, including date and
	signature, for each resident <b>03. Resident Health Status</b> . Conduct a nursing
	assessment of the health status of each resident by identifying symptoms of illness,
	or any changes in mental or physical health status.
	IDAPA 23.01.01.460.LICENSED PRACTICAL NURSE (LPN). <b>02. Functions</b> . A partial
	listing of some of the functions that are included within the legal definition of
	licensed practical nurse, Section 54-1402(3), Idaho Code, (Nursing Practice Act)
	follows. This list is for example only, it is not complete. The licensed practical nurse:
	a. Contributes to the assessment of health status by collecting, reporting
	and <u>recording</u> objective and subjective <u>data</u> ; and (4/2/08).
Can enemas be delegated by	Yes. We would expect to see documented training and delegation to staff
the RN?	(1/22/09).
If a hospice resident has	Not if the facility has written parameters from the physician describing when 911
blackout episodes that are a	should not be called (4/2/07).
part of their disease process	
does 911 have to be called?	
Families have sometimes	The facility should disclose to families during the admission process what level of
become angry when 911 was	nursing the facility has in the building and that when there is not a nurse in the
called. What should we do	building, then 911 will be called, as facility staff cannot assess residents (9/25/06).
about this?	Ultimately, the facility is responsible for ensuring the residents are provided the
	necessary medical care (7/15/09).
Are physician discharge	No. There are no requirements in the rules for this. The facility does, however, need
orders necessary when a	to obtain a copy of all current medication and other physician orders before
resident is discharged from a	admission (10/13/10).
RALF?	
When medications are	If a physician orders a specific time, the medication must be given at that time.
ordered to be given daily,	However, the facility nurse can ask the physician if they would consider a "Generic
twice daily, etc. at specific	Medication Pass." Which means the physician can give a range of acceptable times.
times, can the facility adjust	For example: AM medications will be offered between 5:00 AM and 10:00 AM, noon
the medication times to fit the	medications will be offered between 11:00 AM and 2:00 PM, etc. (11/09/10).

a of controlled medications, however, this
g of controlled medications, however, this 0).
racked and counted. IDAPA
acked and counted. IDAFA
olicy should describe how non-narcotic
olicy should describe how non-narcotic
a nurse. IDAPA 16.03.22.735.03 states
be maintained in the facility and include:
amount; <b>b.</b> Name of resident for
disposal; d. The method of disposal; e.
responsible facility personnel and witness
ainal container and placed in coffee
ginal container and placed in coffee
t of water. This mixture should be placed in the trash (9/5/09).
d by a pharmacists or nurse and labeled
sician instructions: IDAPA
of house supple medications. There is also
ble, in that OTC medications could be
but staff may be used to giving them for a
or the appropriate physician's order.
buying OTC medications in bulk, and
for each individual who has a prescription
1

Do OTCs have to be purchased from the pharmacy?	There is not a requirement that the OTC medications are purchased from a pharmacy. However, there must be a physician's order, the facility must have a variance for bulk medications, and the bottle must be appropriately labeled for each resident. The Board of Pharmacy rules describe what medication labels must include. Some of this information may already be on the bottle or may not apply. The nurse labels the bubble pack or bulk container with the rest. The nurse who fills and labels should initial the label (4/1/09).
	27.01.01.255.04 Name, address and telephone number of the institutional pharmacy. (7-1-93) ii. Date and identifying serial number. (7-1-93) iii. Full name of patient. (7-1-93) iv. Name of drug, strength, and number of units. (7-1-93) v. Directions for use to the patient. (7-1-93) vi. Name of physician prescribing. (7-1-93) vii. Initials of pharmacist dispensing. (7-1-93) viii. Required precautionary information regarding controlled substances. (7-1-93).
If a resident is admitted with	If a resident is not a self-medicator and is admitted with a one month or less supply
a supply of prescription bulk	of his/her prescription medications in bulk, it is okay for them to use them up
meds, can they be used?	without obtaining a variance. However, after the medications are used up, the resident's medications should be bubble-packed or placed in a medi-set. This is only for prescription medications, not OTCs. Likewise, there should not be any reason a resident in AL is not allowed to have OTCs. The facility should assist them to obtain physician orders for the OTCs they need. In addition, a variance is not needed for those things that will not fit in a bubble pack (chocolate chews). 16.30.22.310.01 states each facility must use medi-sets or blister packs. The facility may use multi-dose medication distribution systems that are provided for resident's receiving medications from the Veteran's Administration or the Railroad benefits. The medication system must be filled by a pharmacist and appropriately labeled in accordance with pharmacy standards and physician or authorized provider instructions. A licensed nurse may fill medi-sets, blister packs, or other approved systems as provided in Section 39-3326, Idaho Code and Section 157. IDAPA 16.30.22.310.01.e. states each medication must be given to the resident directly from the medi-set, blister pack or medication container and part f. states residents must be observed taking the medication (5/21/07).
Can a resident's family order	There is nothing in our rules that prohibits this. However, Idaho Medicaid will only
<b></b>	j zamina prominenta in construction in construction of the constru

	Constitution Constitution Product Light Theory
medications from a Canadian	pay for medications from a pharmacy licensed in Idaho. There are no restrictions
pharmacy?	on private pay residents purchasing their medications from Canada (10/13/10).
When a resident leaves the	The medications belong to the resident and therefore should go with the resident.
facility, do the prescription	If the resident passes away, the prescription medications must be destroyed or
medications have to be	returned to the pharmacy. They should not be given to the family or anyone else
destroyed or can they go with	(11/30/10).
the resident?	
Does rule 310.02 mean that	No. PRN medication orders are valid for 15 months unless otherwise changed or
PRN medications that are not	discontinued. Regarding the accumulation rule, this only applies if the medication is
used for more than 30 days	expired or the med order has been discontinued. If there is a current PRN order,
must be thrown out?	and the medications are not expired, then it does not matter when the last time the
	resident took the medication was. IDAPA 16.03.22.310.02 states unused,
	discontinued, or outdated medications cannot accumulate at the facility for longer
	than thirty (30) days. The unused medication must be disposed of in a manner that
	assures it cannot be retrieved. The facility may enter into agreement with a
	pharmacy to return unused, unopened medications to the pharmacy for proper
	disposition and credit. See IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Sections
	664 and 665, and IDAPA 27.01.01, "Rules of the Idaho Board of Pharmacy." A
	written record of all drug disposals must be maintained in the facility (3/19/07).
Do you need to re-label over	No. If they have a bottle of Tylenol in their room, that is fine, as long as the
the counter medications for	original label is on it and the facility/resident includes Tylenol on the resident's
self-medicators?	physician orders (5/21/07).
Can staff give everyone's	No. Staff must sign after each medication is punched or after each resident
	consumes the pills. The facility policy should address how exactly this is to be done
meds and then go back and	
sign for them all at once?	(10/2/08).
Does a resident have to have	If a set daily dosage of insulin is drawn up in advance by the nurse, and the
his or her dosage of insulin	resident can physically inject the medication without prompting or direction and the
memorized to be considered	resident can stated this is my insulin and it is for, then is would be sufficient for
self-administering?	the resident to be considered self-administering. They do not have to have the
	dosage memorized (12/8/08).

The nurse should assess the resident as safe to do this prior to practice being used. Only the nurse can pack meds in to a medi-set or other container. If the resident is not safe to take the daily dose with them and take it independently at
the appropriated time, the facility should make arrangements with the day
treatment to assist the resident with medications while they are there. The
pharmacy can pack two bubble packs for one medication (One pack has weekdays
and is taken to the day treatment. The other has only weekend doses and stays at
the house) (3/18/09).
Yes, but if you have the order, you must have the medication and vice versa. See
IDAPA 16.03.22.305.02 & 310.02 (1/16/08).
No, if a facility uses re-cap orders and a medication disappears from one order to
the next, it should <b>NOT</b> be considered discontinued. The facility should verify the
discrepancy with the physician and get a discontinue order in writing (8/06/07).
If the med aide recalls giving the medication, they could go back and sign the
MAR. This should not be done more than 24 hours after the medication was
given. The facility policy must describe this process. IDAPA 16.03.02.157.01
states that each facility must develop written medication policies and procedures
that detail receiving of medications and documentation requirements (8/6/07).
The Medication Assistance Course is taught with the assumption that the resident
would otherwise be able to take their own medications except for unusual
circumstances such as a physical disability, mental illness, etc. The BON Rules lay
out a process and every situation is unique. So it is left up to the licensed nurse
to determine if the UAP is capable of doing it and if he or she wants to delegate
the task (4/2/07).  Families may be allowed to give Sublingual to a hospice patient in RALF on a case
by case basis with the following considerations:  1) A variance to rule 16.03.220.01 (medication assistance is required as basic
service in RALF) must be obtained from Licensing and Certification. The
licensing agency will talk with both AL and Hospice teams, and may talk with
the family before making final decision on granting the variance.
2) The resident's death is imminent.
Hospice assumes responsibility for all meds and for training the family,
including responsibility for reviewing med orders, ordering, implementing,

	making certain they are obtained, etc.  4) Both the AL and the hospice are responsible if the family fails to administer the medications: Hospice is acting as an outside service, so even though they are responsible for the med regimen as described above, the RALF staff are still responsible to coordinate and monitor outside services. In practice, we would expect to see the RALF nurse monitoring the situation (reviewing the meds, etc. to ensure the services the resident is supposed to be getting are being provided, reviewing hospice notes, care plan, etc.). We expect the RALF to know what the condition of the resident is and what services are being provided by who at all times, regardless of who is actually providing the service. In this scenario, we would be giving a variance for the part of the basic service rule that requires the RALF to provide assistance with medications but not to the part that requires the RALF to monitor the meds. Both the RALF NSA and the hospice care plan should clearly identify that the family is administering the medications and describe how this is being done, when, and by which family member(s). The RALF should be actively involved monitoring the effectiveness of having family give the meds and in ensuring the family is present and giving the medications as ordered to ensure the resident is not in pain as a result of meds not being given (9/12/07).
Can family come in and	No. The facility is required to provide monitoring and assistance with medication
administer insulin?	as part of basic services. Since family members are not employed by the facility
	and licensed to administer insulin, the facility would not be providing the
	appropriate monitoring of the insulin administration. See IDAPA 16.03.22.05. (1/16/08).
Can the wife of a couple who	Yes, if nurse assesses that she is able to do so safely. The nurse should check
lives in our facility put eye	every 90 days, when she does the wife's self-medication assessment, to see the
drops in her husband's eyes?	wife is doing the drops correctly (3/19/07).
The wife is a self-medicator,	
the husband is not.	
Can a friend of the family who	Not unless the facility hires the person, and ensures proper licensing and training,
is a nurse come in and give	background check, etc., and payment is made through the facility. The facility is
the resident's shots?	responsible to provide assistance and monitoring of medications as part of basic
Colf Madianton, A madidant in	services. IDAPA 16.03.430.05 (11/25/08).
Self Medicator: A resident is	Only if the facility hires the family member as a contracted nurse. IDAPA

16.03.22430.05 requires the facility to provide assistance with medications.
· · · · · · · · · · · · · · · · · · ·
Oversight of the medication administration and the resident's response to the
medication is a responsibility of the facility's licensed nurse: IDAPA 16.03.22.300
& 305. Additionally, nursing services must be performed in accordance with Board
of Nursing rules. The facility must ensure the qualifications and the license
standing of the nurse who is a family member (6/18/08).
If the pharmacy's list is signed and dated by the physician, that would be
acceptable. The facility does have to have orders that are signed and dated by the
physician, so a list from the pharmacy without signature or date would not be
acceptable. IDAPA 16.03.22.711.09 states a current list of medications, diet,
treatments prescribed for the resident which is signed and dated by a physician or
authorized provider giving the order (7/03/07).
Yes, if the following is met:
1) The facility nurse closely monitors all changes to the Coumadin and is in
communication with the staff each time a changed order is obtained. The
nurse will need to delegate to staff to implement each new change.
2) The facility has copies of the following in the resident's chart:
a) The Coumadin protocol orders signed by the physician or authorized provider
and
b) The facility physician or authorized provider's order for the resident to attend
the anti-coagulant clinic for management of the Coumadin and
c) The agreement between the physician and the anti-coagulant clinic and
d) The resident's lab orders (so the facility RN can compare the change orders
from the clinic to the Coumadin protocol signed by the physician) (4/16/08).
These dispensing systems are <b>not</b> allowed in Assisted Living Facilities. Similar to
a med cart that has a supply of medications for which there is not an order yet.
When an order comes in, the nurse punches it in and the cart dispenses the meds
needed. Per the Board of Pharmacy, these dispensing systems are <b>not</b> allowed in
Assisted Living Facilities because RALFs do not have a DEA # license from the
Board of Pharmacy that would allow them to have medications in the facility that

	they do not have a current medication order for (8/6/07).
Our residents sometimes get embarrassed when the med aides bring all their medication cards to the dining table. Do they need to pop out the medications in front of each resident?	The medications do not have to be popped in front of the resident in this situation, but be certain staff punch out only one resident's medications at a time, lock the med cart when they leave it, and sign off each of the resident's medications before moving to the next resident. IDAPA 16.03.22.310.01.d states assistance with medication must comply with the Board of Nursing requirements (6/11/07).
Is it okay to start a psychotropic med when a resident initially shows behavior?	No. A physical assessment should be completed first to rule out medical causes, and then other non-drug interventions should be tried before beginning medications. See IDAPA 16.03.22.310.04.a (1/02/07).
Do self-medicators need a variance to keep their medications in bulk form?	No, self-medicators do not need a variance to keep their medications in bulk, because these medications are not part of the facility's distribution system. If a resident is not a self-medicator and is admitted with a supply of his/her prescription medications in bulk, but is switching over to blister as soon as they are used up, it is okay for them to use them up without obtaining a variance. This is only for prescription medications. Non self-medicators should not bring OTCs into the facility unless they are bubble packed. Likewise, there should not be any reason a resident in AL is not allowed to have OTCs. The facility should assist them to obtain physician orders for the OTCs they need. In addition, a variance is not needed for those things that will not fit in a bubble pack (chocolate chews) (5/21/07).
Can a self-medicating resident have family or friend fill their medi-set for them?	Medi-sets can only be filled by a pharmacist or a nurse. In situations where the resident is fully cognizant, and would be able to fill the medi-set themselves, except for a physical disability, it would be acceptable for their family member to assist them as long as the resident was present the entire time the person is filling their medi-set. This should only be done when the resident could do it themselves except for a physical impairment. If resident cannot perform this cognitively, then they probably are not appropriate for self-medicating. The resident must be able to pass the self-medication assessment, including knowing what the pills are, what they are for, and any significant side effects they should be watching for (4/30/07).
PRN Meds with a Dementia	If a resident with dementia can ask for the prn, and the facility RN has delegated

resident: May a resident who has dementia, make a self-assessment to determine if a prn is needed?  When we provide day care, residents bring bulk medications with them. Do we	to staff the resident's prn medications, then UAPs can assist the resident with those medications. Ultimately, the facility RN must determine the cognition of the resident to decide the extent that prns can be delegated to UAPs to assist with. For example, a resident with dementia may be able to communicate pain, but may not be able to state whether 1 or 2 Tylenol are needed. Therefore, the prn order would need to be specific or the RN would need to be called to make that assessment and direct staff (4/30/08).  No. A variance is not needed but the medications must be properly labeled and safe-guarded. IDAPA 16.03.22.345.02.a & b (10/13/10).
need a variance?	
Can a home health or hospice RN fill medi-sets or bubble pack medications for residents?	No. Only the facility nurse employed by the RALF is allowed to do this task in the RALF. IDAPA 16.03.22.220.03.a.vii. refers to the facility's responsibility to assist with and monitor medications. Also IDAPA 16.03.22.310.01 relates to the nurse filling medi-sets or blister packs. This rule does not extend to an RN not employed by the facility (08/01/2012).
Who is responsible for	A licensed nurse must administer the medications. It could be a nurse from the
administering medications	facility or from the hospice agency. The contract between the hospice agency and
when a hospice resident	the facility must specify how it will be handled if a resident becomes unresponsive
becomes unresponsive at the	and thus requires medication administration. The NSA and the hospice care plan
end of life?	also must specify who is responsible to ensure the residents receive their
end of file:	
	medications appropriately. Unlicensed medication aides are only able to assist with
	medications, not administer. A licensed nurse must be available to administer the
	medication when the resident becomes unresponsive. IDAPA 16.03.22.730.03
I because he could also at the a Africa	refers to having copies of contracts with outside service providers (08/01/2012).
I have heard that the time	Our rules do not specify such time-frames. It is up to the resident's individual
allotted for scheduled	physician to determine what time the medication should be given and how long
medications has changed from	before or after the scheduled time a medication can/should be given
one hour before or an hour	(08/01/2012).
after, to 30 minutes before or	
30 after. Is this true?	
When a PSR worker is taking	Yes. The facility still needs to send a list of psychotropic medications or behavior
a resident to the physician	modifying medications to the physician for review every 6 months along with
every month and it is obvious	behavioral updates so the physician can make an informed decision on the

changes have been made to	continued use of the medications. Refer to IDAPA 16.03.22.225.03, 310.04.e, and
the resident's psychotropic	711.09. Additionally, we would expect the PSR worker to give a copy of the
medications, do psychotropic	physician notes to the facility (08/01/2012).
medication reviews still need	
to be conducted every 6	
months?	
If a resident goes to a	Yes. The facility nurse is responsible for reviewing all medication orders for side
specialist and receives an	effects, interactions, abuse or a combination of these adverse effects, and
order that is contra-indicated	notifying the resident's physician of any identified concerns. See IDAPA
with their other medication	16.03.22.305.07. Consider faxing a list of all the resident's medications to the
orders, is the facility	primary physician to ask for clarification. Also refer to IDAPA 16.03.22.305.02, as
responsible for addressing	it relates to the facility nurse verifying the residents' medications are current and
this?	match current medication orders (08/01/2012).
Outside Services	
Do hospice agencies or other	Yes. Any direct patient access individual hired or contracted with on or after
outside service providers	October 1, 2007, must self-disclose all arrests and convictions before having
need to provide the facility	access to residents. The individual is allowed to only work under supervision until
with copies of their	the criminal history and background check is completed. IDAPA 16.03.22.009.03.
employees' criminal history	If a disqualifying crime as described in IDAPA 16.05.06, "Criminal History and
and background checks?	Background Checks" is disclosed, the individual cannot have access to any
	resident (11/9/10).
Should the facility call 911,	Yes, 911 must be called first in this situation. The hospice nurse cannot substitute
not the hospice nurse first if	for the facility nurse (9/15/06).
there is an emergency not	
related to the terminal	
condition?	
Can the hospice/home health	Yes, as long as the delegation is face to face and documented the same as it
nurse delegate to the facility	would be from the facility nurse. The hospice nurse can delegate to facility staff,
staff?	however, staff cannot then train each other. For each staff, training/delegation
	must come directly from either the facility nurse or the hospice/home health
	nurse. Further, the hospice or home health nurse should communicate to the
	facility RN about what was delegated to staff (7/15/09).
<u> </u>	

Resident Rights, Behavior Management, Privacy, Confidentiality	
If the facility wants to switch pharmacy providers, does the resident have the right to refuse to switch to that pharmacy?	Yes - See IDAPA 16.03.22.550.12 (11/09/10).
Can you discharge a resident who refuses to allow staff to clean his room?	The facility must address through contract with the resident, behavior program, family or caseworker involvement, etc. See if the resident will allow a cleaning service to come in. If those efforts fail, and the resident's room in unsanitary, the facility should give a 30-day notice (10/2/08).
Can Power of Attorney (POA) sign for resident?	It depends on the specifics of the POA. A power of attorney can be very broad or narrow. For instance, if it's a general and unlimited power of attorney for health care, the holder of the POA probably has the authority to sign the agreement. However, a POA can also be very limited in terms of both time and power. There's no fixed form for a POA, but a properly written one should show the duration of the power and the circumstances for which the power is given. It may be very limited, such as the power to make veterinary decisions for pets, or sweep very broadly, such as making all decisions the person himself could make. But, a holder of a POA, if properly authorized, should be able to sign an admission agreement. However, the POA might be personally on the hook for decisions made, unlike a guardian. W. Abbott (11/6/06)
Is it against the rules for a resident who takes a medication that is contraindicated with alcohol to consume alcohol?	No. The nurse should be monitoring and notify the physician if the resident uses alcohol and it is contra-indicated with their medications or other health conditions. The physician can determine if the medication needs to be stopped or orders otherwise changed. Facility policy should address how this will be handled (8/4/06).
Is residents having sex prohibited by rule?	No. The facility can have a house rule prohibiting this. If there is a house rule, it should be in the admission agreement too. The facility is responsible to protect residents who are unable to give informed consent (8/18/06).
If a resident wants the bed taken out of their room, must the facility provide one?	No, but the facility should request a variance to the rule 16.03.22.03 (1/16/08).
We have a resident who has	The facility should develop a written agreement regarding driving restrictions that

MD orders/driving restrictions, but continues to drive.	is included in the NSA. Then, if resident fails to comply with agreement, there are grounds for discharge. The facility is responsible to protect resident/others from harm when they know a potentially harmful situation exists. The facility has a responsibility to let the physician and the DMV know if the resident is breaking the
	law (7/15/09).
What do we do with a diabetic resident who refuses to follow their ADA diet?	The resident or responsible party should be informed of the consequences of not following the diet and this information should be documented in the record. The physician should also be notified. This refusal and how staff is to respond, needs to be identified in the NSA. The nurse should re-visit this issue and document status and any changes in the 90 day assessment (10/15/08).
Where is it okay/not okay to use video cameras in a facility? Consents?	It is permissible for a facility to place video cameras in common areas, not bathroom/dressing room. Residents should be informed in the resident admission agreement. A family placing a camera in a resident's room is a guardianship/POA issue; the facility needs to assure placement of the camera will not violate the privacy of other residents (11/20/06).
Is it okay to do random room checks for medications?	This is acceptable only if this practice is described in the facility policy and the resident is notified and agrees to this prior to moving in (3/19/07).
Are locks required on Resident rooms?	There are not rules specific to whether resident rooms should or should not have locks on them. Considerations must be made for resident rights to access their own room without delay or permission, for keeping medications stored in resident rooms locked, and for the need for staff to access to assist with evacuation or other medical emergencies. The resident must be informed who has access to keys if the room is locked (4/1/09).
Can a facility require that they handle the resident's personal funds (the amount they have for spending after Board and Care are paid)?	No. See IDAPA 16.03.22.550.05. a. which states a facility must not require a resident to deposit his personal funds with the facility (3/19/07).
Is a resident inventory required?	No. However, the facility must have a policy to protect resident's belongings. See IDAPA 16.03.22.153.05 (1/02/07).
Can RALFs exclude sexual offenders from their communities?	There is nothing in the RALF rules to prohibit facilities from excluding sex offenders (3/5/08).

What do we do when friends or family pose problems while visiting a resident?	Residents have the right to visitors of their choice with reasonable restrictions (i.e. 3:30 am) 550.07.b &c. The facility must attempt to work with the resident and visitors to minimize disruption or other problems. Banning a person from the facility that the resident wants to have visit would not be a reasonable restriction (4/1/09).
Does the facility have to have a behavior management program for every resident who is on an anti-depressant?	Not necessarily. If the resident is not displaying symptoms or maladaptive behaviors as a result of the depression, then it would be acceptable to just monitor for the symptoms the antidepressant is prescribed to ameliorate (3/5/08).
Is a behavior program still needed if a resident is taking behavior modifying medication and not exhibiting any behaviors?	Yes. The former behaviors need to be documented so staff are aware and can respond appropriately if behaviors occur. Further, the facility is responsible for providing behavior updates for the 6 month psychotropic medication review. If the facility does not maintain a record of what behaviors the psychotropic medication was prescribed to address, then it may not be possible to justify the continued use of the psychotropic medication. Refer to IDAPA 16.03.22.225.01 – 03 (08/01/2012).
I suspect a resident is doing drugs, but I do not have proof. I called the police, but they stated they cannot force the resident to take a UA. Can I still give the resident notice to move out?	Yes, you can give the resident a 30 day notice to move out if you have a valid reason to believe they are doing drugs. Document the behavior and you observations that lead you to suspect drug use (10/2/08).
Smoking: If a resident smokes, but requires constant supervision while smoking, do we have to take the resident out to smoke whenever he wants?	No. The facility needs to establish a policy to address how often it will provide supervision for smoking. Additionally, it needs to be addressed in the resident's Negotiated Service Agreement. The facility and resident should establish a reasonable schedule and negotiate the price for this service (10/2/08).
While residents are being assisted with their medications, is it necessary to keep the MARs secured to protect the residents'	Yes. Often the MARs are left on top of the medication carts and contain private information about residents. IDAPA 16.03.22.330.03 states the facility must safeguard resident information against loss, destruction, and unauthorized use. Also see IDAPA 16.03.22.550.12.c the right to confidentiality and privacy concerning medical or dental treatment (08/01/2012).

privacy?		
Safety, Environment, Restrain	Safety, Environment, Restraints	
What is needed for approval	Plans with dimensions, and the specification sheets for the proposed locking	
of an interior or exterior	devices must be submitted to Division of Licensing and Certification – Fire/Life	
secure environment?	Safety & Construction Program for approval prior to installation (11/9/10).	
A resident has difficulty	"Chair a resident cannot get out of" is referring to a recliner or sofa. The chair with	
staying upright in his w/c,	locking wheels is a wheelchair. As long as the resident can remove the belt	
and has a tendency to lean to	themselves, it would not be considered a restraint. A resident in a recliner or	
the left. The resident needs a	couch that they were unable to get up from independently needs to be checked	
safety belt to help him not fall	frequently. The staff needs to make sure the resident is assisted up when the	
over in his w/c. Question: Is	resident no longer wants to sit. Staff also needs to assure the resident is assisted	
this a restraint? I read rule #	to the restroom, and offered snacks/fluids, change position, etc. as needed	
152.05.iii, and said as long as	(2/22/07).	
the resident is able to remove		
the safety strap by himself		
and whenever he wants it's		
not a restraint. What does		
this mean: "an exception is		
a chair with locking wheels or		
chair in which in which the		
resident cannot get out of;"		
Can we use a baby gate?	While these are not specifically mentioned in our regulations, they would be	
	considered a dignity issue. They would also be looked at very closely to see if	
	they were being used as a restraint and could be an indication there is not	
	appropriate supervision of the residents. Baby gates and other obstructions also	
Com vers manufacture and the	create a potential impediment for safe evacuation in an emergency (6/11/07).	
Can we request a variance to	No. Variances for the use of bedrails will not be granted, as all physical restraints,	
have bed rails for a resident	including bedrails are prohibited in RALFs. One exception is a short term variance	
who wants them?	for hospice residents with air beds that have rails attached. Serious injuries and deaths in Idaho have been attributed to the use of bedrails. If a resident would	
	otherwise be able to get out of bed unassisted, then the rail is not acceptable. A resident who requires the use of a bed rail to keep them in bed is not acceptable	
	· '	
	for assisted living. A full bed rail is never acceptable in a RALF. When a device is	

	needed for positioning, the least invasive, safest device available that still meets the resident's needs should be used. When the survey team encounters a ½ bedrail, a ¼ bedrail, a bed cane, or similar device, a review will be done to ensure that per the RN assessment, the NSA, and resident, staff and family interviews, the resident needs the device for positioning and not restraint. If a ½ or ¼ rail is used, the assessment should specify why a smaller, safer devise would not be effective. The facility should have a policy on the use of these devices. The use of the device must also be addressed in the resident's NSA (6/11/07). IDAPA 16.03.22.152.05. Policies of Acceptable Admissions. Written descriptions of the conditions for admitting residents to the facility must include:  b. No resident will be admitted or retained who requires ongoing skilled nursing or care not within the legally licensed authority of the facility. Such residents include: iii. A resident who requires physical restraints, including bed rails, an exception is a chair with locking wheels or chair in which the resident cannot get out of
	(8/14/09).
Are Transfer Poles considered a restraint?	They are not considered a potential restraint or bed rail, but its use does need to be monitored for safety. A qualified professional should assess the device and the resident and train the resident and staff how to properly use it. Include the pole on the NSA (2/4/09).
Bed Rails: Can beds with air mattresses have a side rail?	If the manufacturer recommends the use of side rails with the product, then a variance to the rule IDAPA 16.03.22.152.05.b.iii. would need to be requested. A variance must be requested for each resident, as a facility wide variance would not be appropriate (4/2/08).
Are bed canes considered a restraint?	Bed canes pose the potential for injury. They need to be assessed by a qualified professional that it is safe and that it is for transfer, not to keep the resident from falling out of bed. The bed cane needs to be included on NSA (11/30/10).
Are gloves a restraint?	They could be if the resident is unable or not allowed to take them off herself. They may also be considered a dignity issue if the resident is wearing them indoors (11/12/08).
Are lap buddy's allowed in RALFs?	A lap buddy would be considered a restraint and therefore prohibited in RALFs by IDAPA 16.03.22.152.05.b.iii, unless the resident was fully cognizant and was consistently able to disengage the lap buddy without assistance (4/1/09).
Our facility has the locks on the bedroom doors turned	No. Seclusions and restraints are both prohibited in RALFS. A resident being in a room they cannot get out of would be considered both (5/18/09).

around (so they lock from the	
outside) is this okay?	
Can we put locks on the gates	No. The Division of Licensing and Certification – Fire/Life Safety & Construction
in our yard? I found an	Program must be contacted prior to any modification of exit doors, delayed egress
automatic lock with a key pad	locks on doors, including automatic locks and delayed egress locks. Unapproved
at Radio Shack. Can I put	locks on doors requiring special knowledge or tools would be cited as a core issue,
these on our doors to create a	and may be considered immediate danger (11/9/10).
secure environment?	and may be concluded an information danier (1 17 77 10).
Is there a state law that there	No. ALFs should take precautions to prevent break-ins. Locking all doors at night
must be one exterior door	would be prudent. The doors cannot be locked from the inside though unless it is a
that remains unlocked at all	secure environment in which case, the doors must automatically unlock in the
times?	event the fire alarm goes off (3/18/09).
Would you define secure	Facilities that have one or more residents who are at risk for wandering must
environment?	provide a secure interior environment to ensure residents do not leave the
	premises unsupervised. The uniform assessment should identify if the resident is
	considered a risk for wandering; if they have attempted to exit the facility, have a
	history of attempting to elope before moving to the facility (from home or another
	setting), or express an intent to leave the facility. Because measures used to
	secure the environment may be effective for one resident, but not another, the
	type of security provided should be evaluated for the effectiveness in protecting
	each of the residents based on their individual needs and abilities, and should be
	adjusted (increased or decreased) as necessary. Examples of measures that could
	be used to secure an environment include keypads, buzzers, alarms, delayed
	egress, etc. These measures should be individualized to each resident and must
	be included in the Negotiated Service Agreement. Should a resident get in a
	situation of potential danger (getting outside the facility or the secure exterior
	yard without staff knowledge) the measures in place must be re-evaluated and
	adjusted to prevent recurrence. In the event a resident is outside without staff
	knowledge or in the event of an elopement, a facility would be cited if they knew
	or should have known of the resident's behavior and did not implement adequate
	measures (7/30/07).
	A secure <b>exterior yard</b> provides an area where residents can spend time outside
	and be safe from wandering away from the premises. A secure exterior yard may

be a fenced area, or a courtyard surrounded by the building. The height and construction of the fence should be sufficient to assure residents are not able to climb over or slip through the fence, or exit a gate undetected. If the secure exterior yard is a part of a means of egress (fire exit) the facility will need to assure the yard does not trap or create a hazard in the event of a fire. Using a delayed egress (push to exit, alarm will sound) or controlled egress (magnetic and key pad) system that are tied to the fire alarm system and automatically fail-safe would enable individuals to escape the yard in the event of fire. The facility should consult with the local fire and building officials, and the licensing authority for approval of such a system prior to installing delayed or controlled egress devices (1/10/08).

# Applicable rules:

IDAPA 16.03.22.010.10—Definition of Assessment

16.03.22.010.14—Definition of Behavior Management

16.03.22.011.02—Definition of Functional Abilities Assessment

16.03.22.011.25—Definition of Negotiated Services Agreement

16.03.22.012.02.c.d—Definition of Personal Assistance

16.03.22.012.25-- Definition of Supervision

16.03.22.152.05.a—Policies of Acceptable admissions

16.03.22.152.01.a states that the admission policies to identify the purpose quantity and characteristics of available services

16.03.22.220.02 requires that the facility include in the admission agreement staffing patterns and qualifications of staff on duty during a normal day.

16.03.22.225.01 &.02 require the facility to evaluate behavioral symptoms and develop interventions for the behavioral symptoms.

16.03.22.250.14. Secure Environment. If the facility accepts and retains residents who have cognitive impairment, the facility must provide an interior environment and exterior yard which is secure and safe.

16.03.22.405.07 states that any locks on exit doors must be single action and easily operable from the inside without the use of keys or any special knowledge. The locking arrangements must meet the referenced NFPA code.

16.03.22.550.03.iii requires facilities to ensure that the living environment is safe and sanitary (7/30/07).

# Are portable heaters allowed?

No. See IDAPA 16.03.22.405.05.f (10/13/10).

How far away from the	There isn't a set distance requirement. Residents and staff should smoke in a
building does the outside	designated smoking area that is not close to weeds, or where there are
smoking area need to be?	combustibles (wood piles, garbage cans, beauty bark, or wooden decks), that
	could catch on fire. Designated smoking areas should provide noncombustible
	ashtrays and a noncombustible self-closing garbage can. If the designated
	smoking area is in the garage, the area would need to be protected by fire
	sprinkler head(s) as this becomes an occupied space (11/30/10).
How do I make my designated	Smoking rules need to be adopted, posted and enforced. Assess residents to
smoking area safer?	ensure they can safely smoke on their own or provide assistance/supervision
	which may include 1:1 oversight. Cigarette butts need to be extinguished in a
	noncombustible ashtray. Ashtrays need to be emptied in a metal butt can that
	has a self-closing automatic lid. Never discard smoking materials into a plastic
	garbage can, or one that is stored in the garage because that could start a garage
	fire. Do not allow residents who require oxygen gas to smoke near their oxygen
	supply or tubes. Smoking by residents who are assessed as not responsible shall
	be prohibited.
What steps must be taken for	The facility policy can prohibit smoking by residents on oxygen. Residents who
a resident on oxygen who	are smokers need to have the oxygen turned off and the oxygen tubing removed
smokes?	from their bodies prior to having their cigarette lit. It would be ideal if there was
	at least a two minute time lapse between the removal of the tubing and the
	lighting of the cigarette. Having residents sign a document that states they accept
	the responsibility if they catch on fire does not absolve the facility of its
	responsibility to provide supervision and a safe living environment (9/25/06).
How do I inspect my fire	Fire extinguishers should be inspected when installed and after the annual visit by
extinguishers every month?	the fire extinguisher service company – this is for quality assurance. Then they
	need to be checked monthly for:
	1) Are they located where they are supposed to be and can anybody get to the
	extinguisher?
	2) Is there a sticker to show how the extinguisher is used and are the tamper
	seals unbroken?
	3) Take the extinguisher off the hanger and check the gauge, hose and nozzle to
	see if there is physical damage, corrosion, leakage, or a clogged nozzle.
	4) Date and initial the tag indicating the inspection has occurred.

	Immediate corrective action should be taken if any fire extinguisher is found to have a condition where it wouldn't correctly operate (11/9/10).
Do the fire drills have to include the actual alarm, or can we just let everyone know we are conducting the drill?	Fire drills shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. Silent drills may be practiced for the night shift when residents are asleep. When drills are conducted between 9:00 p.m. and 6:00 a.m., a coded announcement shall be permitted to be used instead of audible alarms, according to NFPA code. From a practical standpoint, some night time drills should include actual fire alarm and evacuation, otherwise how does a facility know if residents will hear the alarm and respond properly. When a drill is conducted during sleeping hours it is permissible to announce the drill in advance (11/30/10).
Do staff and residents have to actually evacuate in a fire drill?	It depends on the number of licensed beds; small facilities (16 beds or less) – yes, large facilities (17 beds or more) - no.
ariir?	Small facilities need to practice complete evacuation during drills. Drills involve the actual evacuation of all residents to a place outside and provide residents with experience in using all exits and means of escape (as an example, residents need to know windows are a means of escape). During inclement weather evacuation can be movement to the exit or the means of escape. Actual exiting from windows is not required, opening the window and signaling for help is an acceptable alternative.
	Those residents who cannot assist in their own evacuation or who have special health problems are not required to be moved but should participate in the drill to the level that they are capable of. Staff must plan and practice moving residents who cannot self-evacuate using dummies and wheelchairs or other staff members, if needed.
	For large facilities the following applies: a plan is written for protecting all persons in the event of fire, for keeping persons in place inside (which is allowed by more rigid construction), for evacuating persons to areas of refuge (behind smoke barrier doors to another wing for example), and for evacuating persons from the building when absolutely necessary. "Infirm or bedridden patients shall not be required to be moved during drills to safe areas or to the exterior of the building."

	Normally a complete evacuation is not required, only relocation to an area of safety.  For all facilities, a drill is a measure of response of the staff and residents, problems encountered and recommendations for improvement. Staff needs to thoroughly discuss and document issues, know what proper actions are to be taken and seek to change any plan if any resident's condition changes.  For large or small facilities all residents must participate in the drills.
	Why do only the small facilities need to evacuate? Because smaller facilities are constructed differently and have less fire protection capabilities so immediately getting out the building in case of fire is the number one priority (11/12/10).
Are Hoyer Lifts allowed in RALFs?	Yes, with documented training for all staff who use the lift and safe practices observed during survey (3/19/07).
Does a Hoyer lift have to be "delegated?"	No, but staff must be trained on the proper use and the training must be documented. See IDAPA 16.03.22.153.11, 620, 625.03.d, 730.01.e. Also see BON rules for list of items that <u>do</u> need delegation from the nurse (11/9/10).
Hoyer lifts: Do Hoyer lifts require two staff to operate?	It depends. The facility needs to have a copy of the manufacturer's specifications and follow them. If using a lift and only one person is available, be sure to get a lift designed to be operated by one person. Also, make certain all the staff has been trained and the training is documented (3/19/08).
May a facility keep a tank of oxygen on hand for emergencies?	No. If a resident is requiring oxygen, and normally does not require oxygen, then EMS is a more appropriate response. Further, UAP cannot make the assessment to determine whether a resident requires oxygen in an emergency and cannot titrate the oxygen. Further, oxygen is a medication, requiring a physician's order (7/15/09).
Closed toe shoes-Is there a requirement for closed toe shoes?	It is not specifically required in our rules, but is up to the facility's policy and procedures and could be considered a best practice. The facility must ensure that infection control measures are being taken in light of the decision to require or not require closed toe shoes (6/04/08).
Do soiled briefs or clothing have to go into bio-hazard containers?	No. However, if the item is soiled with blood, it may need to. The facility should have policies regarding infection control, including universal precautions. Staff should be familiar with and follow these policies. See IDAPA 16.03.22.335. &

Are common use bars of soap and towels allowed?	335.03. Linens must be handled and processed in a manner that prevents cross-contamination. Resident's personal laundry cannot be washed with the facility's general linens (sheets & towels). IDAPA 16.03.22.260.05.c and h. (10/13/10)  No. To promote good infection control, each resident should have their own bar of soap and a towel. Bar soap and shared towels should never be used in public bathrooms. If staff need to wash their hands while in residents rooms, liquid soap and paper towels should be available to them. See IDAPA 16.03.22.335, 335.03 & 430.06 (11/30/10).	
If two residents share a room,	The rules do not address towel racks. The key though is infection control. We	
do they have to have separate, labeled towel racks?	would be looking for a system to ensure the towels are kept from contaminating each other and the residents are not using each other's towels (10/15/08).	
Staffing, Staff Roles, Employee and Contractor Records		
Is there a minimum resident to staff ratio?	No. According to the rules the administrator is responsible to schedule sufficient staff to meet the needs of each resident. See IDAPA 16.03.22.600.06.a and 152.05.a. (10/13/10).	
Can a facility hire employees	Yes. The facility may hire someone under 18 years of age to do non-resident care	
under 18 to do non-resident care jobs? And would they	jobs. If they have direct patient access (housekeeping, etc.), they must have a criminal history and background check completed. The administrator must ensure	
require a background check?	that no personnel, who provide hands on care or supervision services, will be	
	under 18 years of age unless they have completed a certified nursing assistant certification course. See IDAPA 16.03.22.009.03 & 215.12 (10/13/10).	
Is "horseplay" allowed	No. While it is important for staff to develop rapport with residents, professional	
between caregivers and	boundaries must be maintained. Horseplay can easily be viewed as abuse. It is the	
residents?	administrator's responsibility to supervise and monitor staff/resident relationships. See IDAPA 16.03.22.600.05 (10/13/10).	
How often does staff need a	There is not a requirement for facilities to re-check a staff member who has been	
background check?	continuously employed by them since their initial background check.	
	IDAPA 16.03.22.009.05 New Criminal History and Background Check. An	
	individual must have a criminal history and background check when: a. Accepting employment with a new employer; and b. His last criminal history and background check was completed more than three (3) years prior to his date of hire. IDAPA	

	16.03.22.009.06.c. An employer may use a previous criminal history check that is within three years, provided the employer completes a state-only background
	check (8/7/07).
When a change of ownership	If the Department of Health and Welfare background checks are within three
occurs, does the facility need	years, then a State police Background check would be required. Otherwise, new
to do new background checks	checks would need to be completed (1/22/09).
on the current employees?	
Can medical assistants inject	No, an MA needs to be delegated by a MD before assisting with medical tasks.
insulin for residents who	Therefore, it would be out of scope in an assisted living facility because there is no
reside at an AL?	physician's oversight (2/8/08).
Can MA's (medical assistants)	The same nurse delegation required for a medication assistant is required for an
assist with meds?	MA. The board of nursing determines if a course or training is appropriate to
	prepare someone to assist with medications. The MA would either need a
	medication assistant certification or documentation from the board of nursing that
	their MA training was sufficient to allow them to assist with medications.
	IDAPA 16.03.22.645 Before staff can begin assisting residents with medications;
	the staff must have successfully completed a Board of Nursing approved
	medication assistance course. The training is not included as part of the minimum
	of sixteen hours of orientation training or a minimum of (8) hours of continuing
	training requirements per year. IDAPA 16.03.22.157.02 MEDICATION POLICIES.
	Nurse Delegation. The process the nurse will use to delegate assistance with
	medication and how it will be documented (11/12/08).
Are cooks required to have	Yes. The rules state the facility must train "staff." They do not differentiate
specialized training in	between direct care and other staff. All staff is likely to interact with residents
Alzheimer's/Dementia also?	occasionally and should be trained in the special needs of the population being
	served. 16.03.22.630 (11/25/08).
Are assisted living facilities	Yes, the nurse needs to be available to address changes in the resident's
required to have a nurse on	medication orders, or mental and physical condition to include behaviors.
call 24-7?	IDAPA 16.03.22.300.02. Licensed Nurse. The facility must assure that a licensed
	nurse is available to address changes in the resident's health or mental status and
	to review and implement new orders prescribed by the resident's health care
	provider (7/19/06).
What does nurse delegation	Delegation must involve both verbal and written instructions. See BON rules
entail?	
CIIIdii!	IDAPA 23.01.400.02.g. Determine that the person to whom the act is being

	delegated has <u>documented education or training to perform the activity</u> and is <u>currently competent</u> to perform the act; and h. <u>Provide</u> appropriate <u>instruction</u> for performance of the act. IDAPA 23.01.400.03. Monitoring Delegation. Subsequent to delegation, the licensed nurse shall: a. Evaluate the patient's response and the outcome of the delegated act, and take such further action as necessary; and b. Determine the degree of supervision required and evaluate whether the activity is completed in a manner that meets acceptable outcomes.
	The degree of supervision shall be based upon the health status and stability of the patient, the complexity of the care and the knowledge and competence of the individual to whom the activity is delegated (11/09/10).
May staff draw liquid oral medications into a syringe?	Yes. This is allowed when the syringe is used as a measuring device. Before this occurs, the nurse must train, delegate, and document the delegation (10/13/10).
Does the BON require redelegation each year?	No. The BON rules do not address re-delegation. However, the rules do address monitoring that delegation to ensure staff competency. A licensed nurse must evaluate whether a particular act is within the legal scope of that nurse's practice and determine whether to delegate. Therefore, if the facility changes nurses, the new nurse must delegate each of the tasks to each staff member. See IDAPA 23.01.01.400 (10/13/10).
Does a staff that has completed the H&W course for PCS qualify as medication certified?	No. They have to pass the assistance with medications certification course that is approved by the BON (12/8/08).
Does there need to be a med tech (staff with medication assistance certification) on the night shift?	If any residents take PRN medications on the night shift, there would need to be a med tech there to give them if needed. If the facility uses an on call person to come in if PRN is needed, then the policy plus evidence that someone is available at all times would be needed. IDAPA 16.03.22.600.06 states that there must be sufficient staffing to provide care for all residents (8/6/07).
May staff be trained to write the Dr. Order on the MAR?	There is nothing to prohibit this in our rules (4/1/09).
Is it better to use an administrator designee or use an administrator from another facility?	Using an administrator from another facility is not considered good practice. The administrator designee is someone who acts on behalf of the administrator when the administrator is away from the facility. The designee must know the facility policies and procedures, be familiar with the residents, and know how to respond
	in an emergency situation. The administrator designee does not need to possess

	an administrator's license. The administrator designee may not assume the
	administrator's responsibility for daily oversight and supervision of personnel on
	an ongoing basis. According to IDAPA 16.03.22.215 "Each facility must be
	organized and administered under one (1) licensed administrator assigned as the
	person responsible for the operation of the facility. Multiple facilities under one
	(1) administrator may be allowed by the department based on an approved plan
	of operation." (6/04/08).
Will surveyors be checking for	Yes. See IDAPA 16.03.22.009.03 which states any direct patient access individual
criminal background checks	hired or contracted with on or after October 1, 2007, must self-disclose all arrests
on administrators and facility	and convictions before having access to residents. The individual is allowed to
nurses?	work only under supervision until the criminal history and background check is
	completed. If a disqualifying crime as described in IDAPA 16.05.06, "Criminal
	History and Background Checks," is disclosed, the individual cannot have access to
	any resident (10/13/10).
What is considered "direct	Direct access means just that; a bookkeeper who works at the corporate office
patient access" when	and never sees the resident would not have direct patient access. A person who
referring to criminal history	works in the facility and comes in contact with the residents, regardless of their
checks?	position, would be considered to have direct access. Maintenance and
	housekeeping persons routinely have access, as do many kitchen staff (4/1/09).
After a medication aid has	No. The facility nurse must delegate and provide written and oral instructions to
completed a medication	the medication aide. The nurse should observe that the medication aide is
course approved by the Board	competent before he or she assists residents with their medications. The nurse
of Nursing, can the aide begin	must document the delegation is complete and include his or her signature and
helping residents with their	the date of completion. The proof of delegation must be retained at the facility.
medications?	See IDAPA 16.03.22.300.01 & 730.01.h. (08/01/2012)
Survey and Licensing	

# **Survey and Licensing**

How does a facility get on the abbreviated survey schedule?

There is not an abbreviated schedule. Facilities that have had no core issue deficiencies for two consecutive licensure surveys are to be surveyed at least every 36 months, while those without two consecutive licensure surveys without a core issue are to be surveyed once every 12 months. IDAPA 16.03.22.130.01 states the Licensing and Survey Agency will assure that surveys are conducted at specified intervals in order to determine compliance with this chapter and applicable rules and statutes. The intervals of surveys will be:

# a. Within ninety (90) days from initial licensure followed by a survey within fifteen (15) months. Facilities receiving no core issue deficiencies during both the initial and the subsequent survey will then enter the three (3) year survey cycle. b. Once every twelve (12) months, or more frequently at the discretion of the Licensing and Survey Agency for those facilities receiving core issue deficiencies during any survey. Surveys will be conducted until the facility attains two (2) consecutive surveys, excluding follow-up surveys, without a core issue deficiency. c. At least every thirty-six (36) months, for those facilities having attained no core issue deficiencies for two (2) or more consecutive surveys, regardless of survey type (4/03/07).

# Are there 2 types of infractions a facility can be cited for?

Yes. A core and a punch. A core issue could be one very serious instance of non-compliance. It could also be a collection of non-core situations that taken together indicate there is a system failure. A core issue is any one (1) of the following: abuse; neglect; exploitation; inadequate care; a situation in which the facility has operated for more than thirty (30) days without a licensed administrator designated the responsibility for the day to day operations of the facility; inoperable fire detection or extinguishing systems with no fire watch in place pending the correction of the system; or surveyors denied access to records, residents or facilities.

Core Issues are used to identify incidents of non-compliance that:

- o Result in harm
- o Have a potential for harm
- o Indicate a breakdown in facility systems that could lead to harm. Non-core issues would be things such as a past due inspection of the furnace, fire extinguishers", smoke alarm inspections, etc. Non-core issues are those that do not rise to the level of core or do not meet the definition of core as described above. The facility does need to fix non-core issues and send evidence that it has been fixed within 30 days of the exit (2/26/07).

# Miscellaneous

Sexual Offender Notifications: When we notify residents that there is a resident on the SO You are not required to state who is on the list, but your policy should describe how notification is to be done. Each resident should be informed upon admission if the facility accepts sex offenders. Document the date each resident is notified

registry, do we need to tell	(10/2/08).
them which resident it is and	Defer to IDADA 1/ 02 22 152 ADMISSION DOLLGIES
how does it need to be documented?	Refer to IDAPA 16.03.22.152 ADMISSION POLICIES  01. Admissions. Each Facility must develop written admission policies and
documented:	procedures. The written admission policy must include; (3-30-06)
	d. Notification of any residents who are on the sexual offender registry and who
	live in the facility. The registry may be accessed
	at http://www/isp.state/id.us/identification/sex_offender/public-access/html
If a resident passes away	This depends on your facility policy and the expectations of your local coroner.
unexpectedly, who do we	Each county is different. Local coroners have the authority to determine under
call?	what circumstances they want to be notified. If you are unsure, contact your local
	coroner for direction in writing your facility policy. Hospice cases are typically
POST: Does the state require	handled by the hospice agency (10/15/08).  No. Our rules do not require that residents have a POST. However, it is a good
all residents to have a POST?	idea as the POST becomes more and more common to ensure the Resident's
un residents to have a rest.	wishes are carried out (10/2/08).
Are electronic signatures	The rules do allow for facilities to develop and use e-records and signatures. They
acceptable on all orders,	must have systems in place to ensure confidentiality and security of data that no
H&P's etc.?	one may alter another's entry. There must be systems in place to provide
	alternate methods of record keeping in the event of a system disruption.
	Rule references:
	IDAPA 16.0322.010.27Definition of Electronic Signature, E-Signature 16.03.22.159.02Deals with the policies re: electronic records
	16.03.22.700—Records (4/13/07).
Electronic records storage:	Yes, as long as they are accessible (printable) to surveyors immediately and to
Can a facility scan their	residents within one day of request. There must be an off-site back-up to the
historical records onto a	electronic records in case of disaster or computer failure. Copies of all resident
computer so they don't have	records must be kept for three years (3/19/08).
to store all the hard copies?	
NSA: What if a resident will	Note on the NSA the date and time the NSA was reviewed with the resident and
not sign the NSA, but does	the resident's response (10/2/08).
agree to the care?	The only rule specific to animals is, no live animals in the kitchen. The facility
What are the rules regarding pets?	The only rule specific to animals is: no live animals in the kitchen. The facility
hers:	does need to assure residents' right to a safe and sanitary living environment

(5/21/07).
No, but if they don't, they must notify the residents in writing per IDAPA
16.03.22.220.05 and the staff per IDAPA 16.03.22.730.01.c (11/30/10).
No, but there are a number of rules that address the facility's response to such an
incident. The facility would need to make sure staff is appropriately trained to
respond to physical aggression. There should be enough staff to keep the resident
and others safe. The behavior must be assessed and an appropriate BMP
developed. See IDAPA 16.03.22.152.05.3, 153.06, 225.1-3 and 320.02.i
(10/13/10).
If the facility is billing Medicaid for is care, then yes, he must be treated as a
resident and meet all rules. If Medicaid is not paying for care, then he does not
need to be counted as a resident (10/2/08).
Our rules do not prohibit slot machines. However, the Idaho state slot machines
and gambling are regulated by the state. You would want to talk with your local
police or sheriff before purchasing any (10/15/08).
18-3810. SLOT MACHINES POSSESSION UNLAWFUL EXCEPTION.
(1) Except as otherwise provided in this section, it shall be a misdemeanor for any person to use,
possess, operate, keep, sell, or maintain for use or operation or otherwise, anywhere within the state of Idaho, any slot machine of any sort or kind whatsoever.
(2) The provisions of section 18-3804, Idaho Code, shall not apply to antique slot machines. For
the purpose of this section, an antique slot machine is a slot machine manufactured prior to 1950,
the operation of which is exclusively mechanical in nature and is not aided in whole or in part by
any electronic means.
(3) Antique slot machines may be sold, possessed or located for purposes of display only and not
for operation.  (4) An antique slot machine may not be operated for any purpose.

A

abuse · 9, 13, 26, 37, 41

ADA diet  $\cdot$  28

administrator  $\cdot$  1, 5, 13, 37, 39, 41, 43 admission agreement  $\cdot$  7, 8, 11, 27, 28, 32

Adult Protection · 6, 13 air mattresses · 31 January 9, 2013

allegations · 13 assessment · 1, See

В

baby gate · 30

**background check** · 22, 26, 37, 40

bathroom · 9, 28 bed rails · 30 behavior · 24, 25, 27, 29, 32, 43 billing · 8, 43 bio-hazard · 36 Board of Nursing, · 40

# C

cafeteria pricing · 7 catheter · 4, 15 change of ownership · 38 charge · 6, 7, 9, 10, 11 charges · 6, 7, 8, 10 colostomy · 3 conservator · 8, 9 core · 32, 40, 41

## D

debrided · 5 delegation · 3, 5, 15, 16, 17, 26, 36, 38, 39, 40 dialysis · 3, 13 Diet · 12, 15 door · 32

# E

**electronic signatures** · 42 environment · 6, 9, 30, 32, 34, 42 evacuation · 28, 30, 35 exploitation · 9, 13, 41 **exterior** · 30, 32, 35

### F

family · 4, 11, 19, 20, 21, 22, 24, 27, 28, 29, 30, 43 fire alarm · 32, 35 fire drills · 35 Fire extinguishers · 34 Food Code · 12 friends · 29 January 9, 2013

funds · 6, 28 Furnishings · 10

# G

game meat · 12 gloves · 9, 10, 31 G-tube · 5, 15 guardian · 6, 8, 9, 27

# Н

home health · 4, 15, 25, 26 Hoyer lift · 36 Hoyer Lifts · 36

#### 1

injection · 2, 22 insulin · 2, 20, 22, 38 insurance · 43 IV therapy · 2, 3

#### L

**locks** · 28, 31, 32

#### M

MAR · 16, 21, 39 Medicaid · 8, 9, 10, 19, 20, 30, 32, 43 medication · 1, 2, 6, 14, 17, 18, 19, 20, 21, 22, 23, 24, 27, 36, 38, 39 medication aid · 40 medications · 1 Morphine · 2

# Ν

neglect  $\cdot$  9, 13, 41 negotiated service agreement  $\cdot$  6, 7 **NG tubes**  $\cdot$  2 notice  $\cdot$  4, 6, 7, 11, 27, 29

# 0

orders · 1, 5, 14, 15, 17, 19, 20, 21, 23, 24, 26, 27, 38, 42 **oxygen** · 1, 15, 34, 36

#### P

Pets · 12
physician · 4, 11, 13, 15, 16, 17, 18, 19, 20, 21, 23, 25, 26, 27, 28, 36, 38
PICC lines · 2
POA · 5, 27, 28
points · 7
Porta Catheter · 6
POST · 42
pressure ulcer · 4, 5
private pay · 8, 10, 19
psychotropic · 24, 25, 29
punch · 21, 24, 41

## R

rate ⋅ 6, 7, 8, 10, 11 rent ⋅ 6, 10 restraint ⋅ 30, 31

RN · 15, 16, 17, 23, 24, 25, 26, 30

### S

secure environment · 6, 32

Sexual Offender · 41

sexual offenders · 28

skilled nursing · 3, 5, 30

smoking · 13, 29, 34

snacks · 30

SNF · 5

soap · 9, 10, 37

staff · 1, 2, 3, 4, 5, 6, 12, 13, 14, 15, 16, 17, 18, 20, 21, 23, 24, 26, 27, 28, 29, 30, 31, 32, 34, 35, 36, 37, 38, 39, 40, 43

supplies · 8, 9, 10, 12

survey · 30, 36, 40

syringe · 2, 39

# T

Telephone · 10 training · 2, 3, 5, 8, 15, 16, 17, 21, 22, 26, 36, 38 transfers · 6, 9 Tuberculosis · 4 two-person assist · 6

# U

unstageable pressure ulcer · 4

# W

wheelchair · 30